2016 ILHPG Priority Populations Final

Presented at August 28, 2015 ILHPG Meeting

Priority Pop. and Rank	Weighted Priority (%)	Sub-Populations and Rank	Weighted Priority (%)	Female (%)	Male (%)
1: MSM	61.2	1.1 NH White MSM	25.7		25.7
		1.2 NH Black MSM	22.7		22.7
		1.3 Hispanic MSM	9.7		9.7
		1.4 Other MSM	3.1		3.1
2: Het. Cont.	23.9	2.1 NH Black HRH	12.8	8.6	4.3
		2.2 NH White HRH	6.3	4.5	1.8
		2.3 Hispanic HRH	3.9	2.0	1.8
		2.4 Other HRH	0.9	0.7	0.2
3: IDU	10.8	3.1 NH Black IDU	6.0	2.1	3.8
		3.2 NH White IDU	3.5	1.9	1.6
		3.3 Hispanic IDU	0.9	0.4	0.5
		3.4 Other IDU	0.4	0.2	0.3
4: MSM/IDU	4.1	4.1 NH Black MSM/IDU	1.7		1.7
		4.2 NH White MSM/IDU	1.9		1.9
		4.3 Hispanic MSM/IDU	0.4		0.4
		4.4 Other MSM/IDU	0.1		0.1
Perinatal	Not Included				
Total	100		100		

Statewide HIV prevention services should reach each priority population and sub-population in equal proportion to the percentages specified in the table above.

Priority populations were derived using statewide surveillance data on the epidemic (excluding Chicago). HIV disease incident cases and late diagnosis cases between 2006 and 2009, and HIV disease prevalence as of 12/31/2010 were used. In order to maximize proportional accuracy, this process only considers cases with known exposure category. The prioritization process for the 2012-2016 Jurisdictional Plan was approved by the then Illinois HIV Prevention Planning Group (ILHPG) on July 14, 2011 and weights of 90%, 5%, and 5%, respectively, were applied to each set of data. Updated epidemiologic data, reviewed by the ILHPG in 2012 and 2013, showed little change to the epidemiologic distribution of HIV in the jurisdiction, so the ILHPG Epidemiology/Needs Assessment Committee recommended that the Illinois Department of Public Health maintain the same priority populations, recommendations, and considerations. The numbers on the table above are rounded to the nearest tenth percent. Priority populations should include information on risk category and race/ethnicity whenever possible.

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Prioritization Points of Consideration

1. **HIV+ individuals** falling within any of the risks identified above should be prioritized within each subpopulation category.
   HIV positive persons with "Other Risk" are prioritized for are prioritized for biomedical interventions intended to link or reengage them into HIV medical treatment and to strengthen their treatment adherence:
   Population Definition: HIV positive person with Other Risk is defined as a person of any gender who:
   - is not known to meet the MSM, IDU, HRH, or MSM/IDU definitions,
   - Never had anal sex with a Male in their lifetime
   - Never had vaginal sex with a Female in their lifetime
   - Never shared injection equipment in their lifetime

   HIV positive persons disclosing no sexual or injection risk are not prioritized for Behavioral Interventions to reduce sexual or injection risk until such a relevant risk disclosure is made. They are prioritized for biomedical interventions until that time.
2. **Transgender individuals** may be included within any priority population based on personal risk history and current gender identification. Transgender identity does not mean an individual engages in risk behaviors. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender females are a high priority for HIV prevention services. The positivity rate among transgender women tested by all IDPH and DASA funded project throughout Illinois between 2008 and 2013 was 1.9%, falling between the HIV seropositivity rates for African American MSM (2.8%) and Latino MSM (1.8%). Young adults with any of the risks identified above should be prioritized within each subpopulation category.
3. **Persons made vulnerable** by circumstances such as incarceration or domestic violence may be prioritized in any risk group when their individual risk and biomedical histories include prioritized risks defined above.
4. **Young adults** with any of the risks identified above should be prioritized within each subpopulation category.

Recommendations:

MSM

1. HIV prevention services need to reach MSM. MSM account for the majority (61%) of new HIV cases in the past five years. MSM also represent the vast majority of the increase in new cases over this period. CTR and HERR services need to prioritize reaching this group's share of incident cases.
2. New cases among young MSM are growing faster than any other group and need to be prioritized. 20-30 year-old MSM represented the largest share of the statewide increase in new HIV cases between 2006 and 2009.[1] Yearly incidence among 20-30 year-old Black MSM went up by 40% in statewide data including Chicago between 2006 and 2009. By contrast, new infections among most groups other than young MSM went down or stayed the same.
3. Geographic differences of MSM incident cases across race/ethnicity need to be taken into account. White MSM incident cases are distributed in low density across the state while the majority of Black MSM incident cases are concentrated around fewer metropolitan areas. Latino MSM cases are highly concentrated in the Chicago metropolitan area (Regions 7 and 8).

[1] In 2009, there were 109 more cases than in 2006, statewide. Although most groups experienced a decrease in new cases, MSM 13-29 accounted for 83 cases of the increase in new cases. It should be noted that there were 128 more cases with no risk identified (NRI) in 2009 than there were NRI cases in 2006. As the NRI cases are investigated, MSM and other groups will most likely also see a proportional increase in numbers given that these cases tend to mirror cases with known exposure category.

Heterosexual Exposure

4. Targeting with precision among high risk individuals is needed. Heterosexual exposure accounts for one quarter of the new HIV cases between 2006 and 2009. Although the number of services reaching this group is the largest of any exposure category, the positivity rate among heterosexuals is low. Furthermore, the proportion of cases attributed to HRH has decreased since 2006. At the same time, HRH are twice as likely to be diagnosed late when compared to MSM. This seeming contradiction indicates that efforts need to be made not to provide more services to individuals with some heterosexual risk, but rather, that the mechanism to target high risk heterosexuals needs to be prioritized and high risk individuals need to be prioritized within this risk group.

IDU

5. Proven services to IDU need to be maintained to sustain the decline in new cases among IDU. New cases among IDU averaged 10% of the epidemic between 2006 and 2009; however, there has been a notable declining trend over this same period of time. This decline might be **attributable, in part to successful interventions that need to be continued in order to prevent a** return of previous figures. Targeting efforts might also need to be emphasized given that IDUs (like HRH) are twice as likely as MSM to have a late diagnosis.

MSM/IDU

MSM/IDU represents about 4% of diagnoses between 2006 and 2009 and presents a unique challenge given the combined risk of MSM and IDU above.

Other recommendations:

6. Special attention should be paid to populations with high rates of late diagnoses who fall within any of the risks identified above. Relative to whites, Hispanics were 47% more likely to have a late diagnosis. There was no difference between whites and blacks. Females were 37% less likely to have a late diagnosis than males. Older individuals are more likely to be diagnosed late. Regions 7 and 8 have the highest proportion of late diagnoses.

7. Regional allocation of services needs to match regional changes in new cases. Regions 4, 7 and 8 have experienced significant increases in new cases between 2006 and 2009. Trends by race/ethnicity and age should also be taken into account in regional allocation. Overall, nearly 60% of 2006-2009 diagnoses were between the ages of 20-39 at the time of diagnosis. However, diagnoses among African Americans tended to happen at a younger age.

Note: In preparation for the start of a new federal HIV Prevention grant Funding Opportunity Announcement (FOA) to begin in 2017 and for development of an integrated HIV Prevention and Care Plan for 2017-2021, the EPI/Needs Assessment Committee has begun the process of planning for a thorough review and analysis of the epidemiology data for next year. In this process, which will commence later this year, we will be utilizing the 2015 Risk Prioritization Size Estimates by Race; Age; and Gender that have preliminarily been compiled by the committee. As 2016 progresses a full data analysis including testing data for risk disclosure and seropositivity will be completed and presented to the full general membership.